

BOLDT (H. J.)

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PELVIC ELEVATION IN ABDOMINAL SURGERY

With a New Transportable Table for obtaining this posture.

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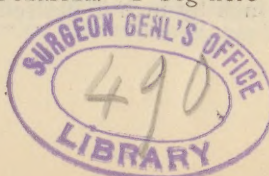
Pelvic elevation in abdominal surgery is a greater advance towards the saving of life than the introduction of drainage of the abdominal cavity. Although this statement will doubtless meet with opposition from not a few sources, yet I am personally so convinced of the correctness thereof that I have no hesitation in making the above assertion, and have no doubt but that eventually it will generally be accepted as correct.

My reasons for taking this stand are that we see everything which we do in the abdomen, there is not an adhesion severed, not a ligature placed, not a scissor cut made without the aid of sight. The intestines are always left within the abdominal cavity during operation; which is of importance in lessening the danger of intestinal paralysis which does occur occasionally when eventration is resorted to.

I do not share the views of operators who look upon this posture with contempt and say that the good surgeon can discard it and work equally well with the sense of touch. It seems to me that the conscientious surgeon should make use of every advantage offered which is of interest to the patient. By being able to see our work we avoid injury of the intestines or of the ureters; we can place a ligature more exactly; we see the source of existing hæmorrhage and its nature, consequently we are better able to deal with it intelligently; we can more readily avoid rupture of a pus-sac of any kind during enucleation and can place napkins or sponges in such manner as to catch the pus in the event of a rupture thus avoiding infection of the peritoneal cavity. Flushing the abdominal cavity and draining it in case that pus accidentally escapes into it, is certainly not as safe as to avoid contamination altogether.

It is now nearly five years since I began to use pelvic elevation in Hospital and in private practise for some difficult abdominal operations, hence it must be conceded that my recommendations are based upon sufficient experience. I had a wooden frame made at that time, to place and fasten upon an ordinary operating table which had the shape of the portable steel band frame which Dr. KRUG recently had constructed. The contrivance, however was too bulky: the patient could not be changed in position without considerable trouble and delay, and it has the same objection which is found in all other tables and also in the movable portable frame alluded to, namely, that the circulation in the vessels of the neck is impeded during the pelvic elevation.

I have since thought about contriving an operating table for the same purpose which should have the advantage of easy transportation and simplicity of management during operation. I think that my object has been achieved in the table presented. The idea of making it from steel bands has been derived from the table constructed by Dr. FOERSTER. I beg here to render my thanks to



RICHARD KNY & Co. for their generosity in having had several models constructed for me.

The advantages of my table are manifold: It is very easy to transport on account of the small amount of space which it occupies; its light weight, 40 lbs. when of steel and about 60 lbs. when of wrought iron; but the main features upon which I lay stress are, that the operator can without the assistance of anyone elevate the pelvis to any desired height by means of the handle which is protected at such time with a sterilized towel, the lowering of the table is obtained in the same manner. A catch on the cogwheel prevents the possibility of the table slipping back from the height to which it has been elevated, and when it is desired to lower the table it is only necessary to throw the catch off the cogwheel. Another movable catch at the foot of the table prevents the possibility of it being accidentally raised too high. The handle, which is reversible to either side, so that in case the operator prefers to have an assistant on the other side attend to the raising and lowering of the table it can be done.

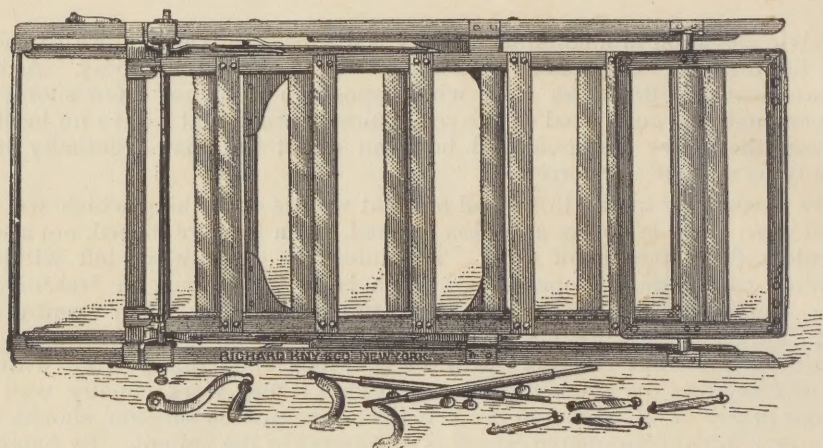


Table Folded Up.

The vessels of the neck are not compressed when the pelvis is elevated as is the case with all other tables and contrivances with the exception of the Trendelenburg chair, thus pelvic elevation on this table permits unimpeded circulation through them, an advantage which should be obvious. The patient can not slip down, owing to the support afforded by the movable shoulder braces, which are padded and can be set for any patient whether tall or short, corpulent or slender.

The anæsthesia with the patient in such position, i. e., without any interference with the circulation by distortion of the vessels of the neck is much smoother and I dare say safer, whether Ether or Chloroform is used. Another advantage is offered by this table, even if the pelvic elevation is not intended to be used during operation, viz.: if from the administration of the anæsthetic a condition results which would make it desirable to obtain temporary cerebral congestion this can be accomplished most perfectly in a moment without taxing the physique of any one, and also without necessitating a disarrangement of the sterilized or antiseptic coverings surrounding the field of operation.

Another and final advantage which I wish to have considered in the employment of this table when extreme pelvic elevation has been employed during an operation—it is not without danger to have the patient placed too suddenly in a horizontal position, it may cause serious syncope from the too rapid disturbance in the equilibrium of cerebral circulation—on this table this can be avoided with the greatest ease and without exertion, the patient can be let down very gradually and the lowering stopped inch by inch if desired.

A large heavy rubber pad covering the table and thus obviating the pressure effects caused by the steel bands is supplied if desired, or the operator can cover the table with a woolen blanket and cover this with a rubber sheet or a Kelly pad, if he desires or anticipates to flush the abdominal cavity. A contrivance is made to attach to the bottom of the table to catch the water in case flushing is resorted to, if this is preferred by the operator; but as noted previously, I believe, that when operations are done with the employment of the pelvic elevation it will seldom be necessary to resort to such recourse. The heavy rubber and the water receiver are independent of the table and left to the taste of each operator.

The credit of bringing pelvic elevation into more general use for the application of pelvic and abdominal surgery belongs to Trendelenburg, hence this posture is usually termed Trendelenburg's posture; yet I must here enter a very

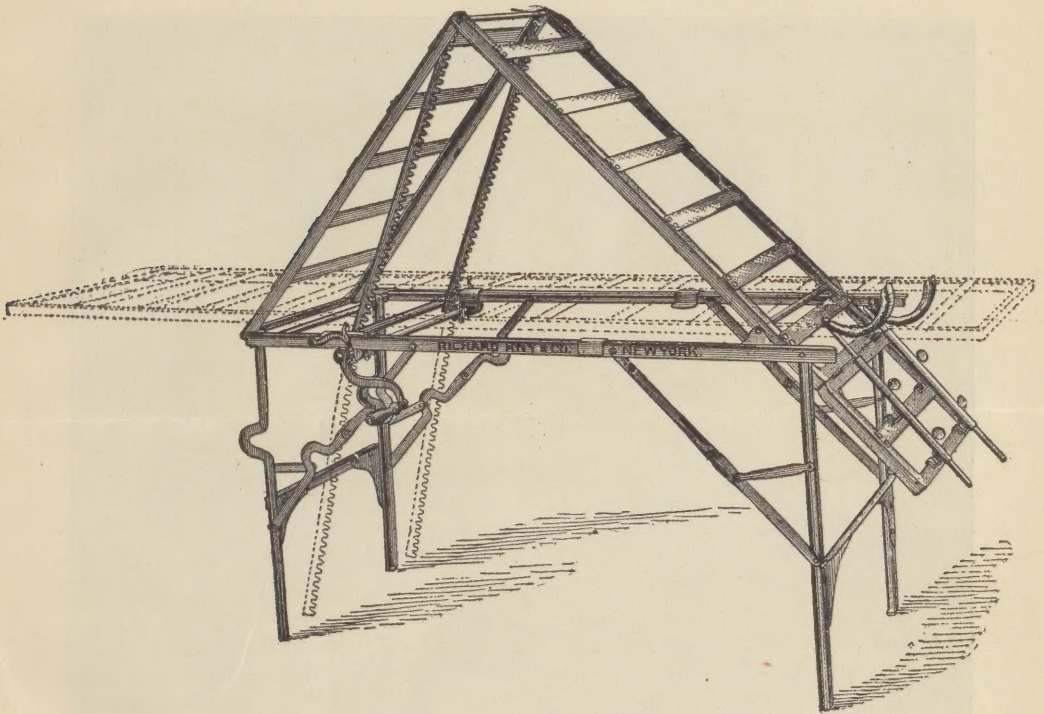


Table when Elevated and Horizontal.

strong protest against the adoption of this term, for obvious reasons. We have already too many terms in medicine to which is attached the name of the particular person who first described the respective disease or symptom or operation, so that I am certain that not a single physician can give a definition of all. It is certainly not my intention to endeavor to impair the honor justly due our brilliant *confreres* for their ability and their discovery, and any writer can give them such honor and credit in his work, even if a few words more are requisite. I, for one, fully recognize the credit and honor due Professor Trendelenburg for having made generally known, through Professor Meyer, the advantages of pelvic elevation; but the compound word "Trendelenburg posture" does not convey to anybody what is meant any more than Fehling's operation (removal of the ovaries for the cure of osteomalacia), or Schnecking's operation (vaginal fixation of the mobile retroposed uterus). I sincerely hope that writers will be more definite, so that not only the specialists in their respective line will understand what they mean by a respective term, but that every physician may be able to comprehend what they mean without looking over books for reference, perhaps in vain.

In this country pelvic elevation became better known through the writing of Dr. Willy Meyer, and later Dr. Krug also brought it to the notice of gynæcologists. However, long before it was recognized, over 20 years ago our justly esteemed colleague, Dr. Emil Noeggerath, used this same posture in nearly every difficult abdominal operation. I do not however sanction the employment of pelvic elevation in all cases of abdominal surgery, because it is necessary to make an incision double and treble the length to utilize the benefit of the posture than one needs without it, but what I do say is that we ought to use a table of some description by means of which we can get pelvic elevation at once without inconvenience, should circumstances demand it. It is claimed that it makes no difference how long an abdominal incision is made, yet I believe if an abdominal operation was to be performed on any of us, we would prefer to have the cut as short as the safety of the operation will permit.

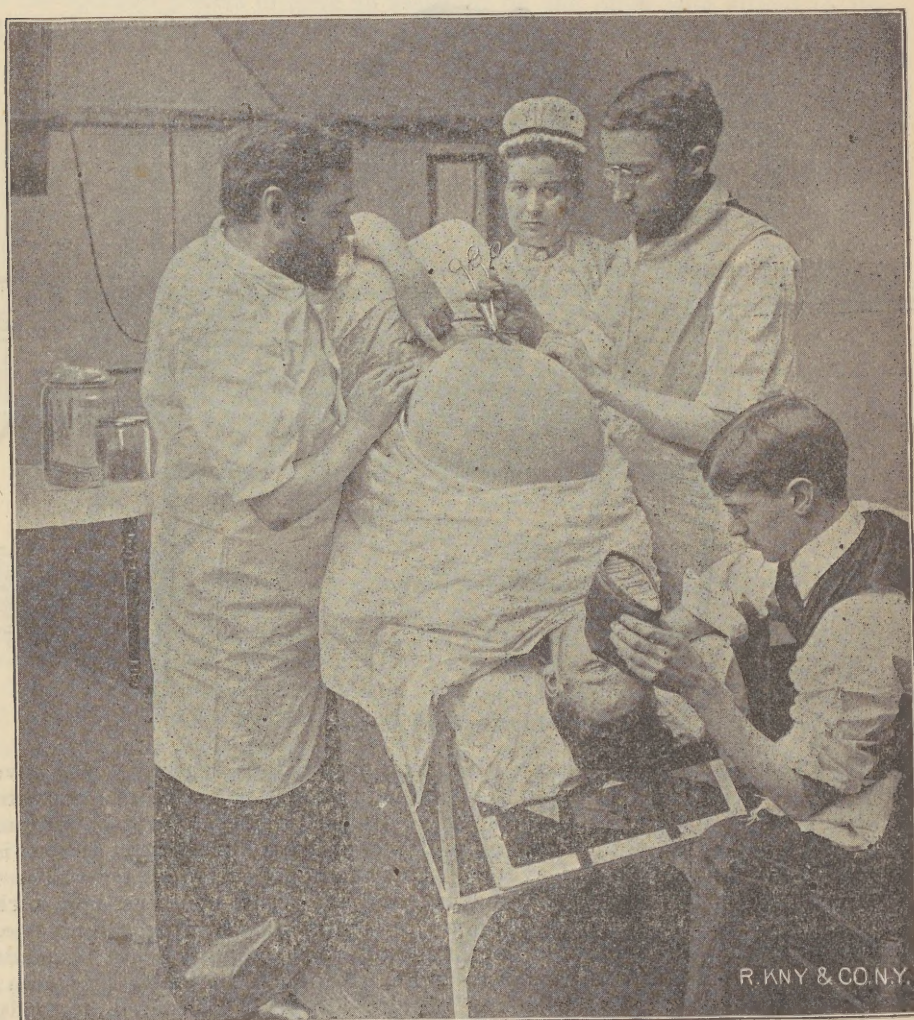


Table when in Use, Showing Even Plane Between Trunk, Neck and Head.

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